FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027961

Facility Name: Nokomis Golden Manor

Address: 505 Stevens (Number) Nokomis (City) 62075 (Zip Code)

County: Montgomery

Telephone Number: (217) 563-7725 **Fax #** (217) 563-2022

IDPA ID Number: 37-1128552-1

Date of Initial License for Current Owners: 04/01/1983

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller **Telephone Number:** (618) 465-7717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) Compilation Report Attached (Date)

(Print Name and Title) Cindy A. Tefteller, Partner

(Firm Name & Address) C.J. Schlosser & Company, L.L.C.
233 East Center Drive, Alton, IL 62002

(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Nokomis Golden Manor # 0027961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	102	Skilled (SNF)	102	37,230	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	102	TOTALS	102	37,230	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	763	180	2,567	3,510	8
9	SNF/PED					9
10	ICF	15,562	6,432		21,994	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,325	6,612	2,567	25,504	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.50%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/1983

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/1983 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 12 and days of care provided 2,567

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Nokomis Golden Manor # 0027961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	117,284	9,105	7,755	134,144		134,144		134,144			1
2	Food Purchase		113,477		113,477		113,477	(3,238)	110,239			2
3	Housekeeping	57,581	11,021		68,602		68,602	112	68,714			3
4	Laundry	51,559	10,817		62,376		62,376		62,376			4
5	Heat and Other Utilities			80,636	80,636		80,636	798	81,434			5
6	Maintenance	30,023	57,347	1,800	89,170		89,170	12,391	101,561			6
7	Other (specify):* Sanitation			2,174	2,174		2,174		2,174			7
8	**TOTAL General Services**	256,447	201,767	92,365	550,579		550,579	10,063	560,642			8
	B. Health Care and Programs											
9	Medical Director			6,500	6,500		6,500		6,500			9
10	Nursing and Medical Records	1,074,637	35,020	39,646	1,149,303		1,149,303		1,149,303			10
10a	Therapy			361,146	361,146		361,146		361,146			10a
11	Activities	38,034	5,268	2,297	45,599		45,599		45,599			11
12	Social Services	32,024			32,024		32,024		32,024			12
13	Nurse Aide Training			2,028	2,028	(885)	1,143		1,143			13
14	Program Transportation		1,483		1,483		1,483		1,483			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,144,695	41,771	411,617	1,598,083	(885)	1,597,198		1,597,198			16
	C. General Administration											
17	Administrative	63,951	13,110	185,000	262,061	(6,093)	255,968	(127,855)	128,113			17
18	Directors Fees											18
19	Professional Services			17,459	17,459	1,451	18,910	1,619	20,529			19
20	Dues, Fees, Subscriptions & Promotions			9,889	9,889	3,151	13,040	(2,836)	10,204			20
21	Clerical & General Office Expenses	20,756	18,411	15,886	55,053	325	55,378	39,742	95,120			21
22	Employee Benefits & Payroll Taxes			273,652	273,652		273,652	11,810	285,462			22
23	Inservice Training & Education					885	885		885			23
24	Travel and Seminar			1,213	1,213	1,166	2,379		2,379			24
25	Other Admin. Staff Transportation							910	910			25
26	Insurance-Prop.Liab.Malpractice			61,177	61,177		61,177	2,196	63,373			26
27	Other (specify):*											27
28	**TOTAL General Administration**	84,707	31,521	564,276	680,504	885	681,389	(74,414)	606,975			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,485,849	275,059	1,068,258	2,829,166		2,829,166	(64,351)	2,764,815			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Nokomis Golden Manor #0027961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			85,849	85,849		85,849	(13,069)	72,780			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			38,099	38,099		38,099	583	38,682			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			123,948	123,948		123,948	(12,486)	111,462			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		55,508	5,796	61,304		61,304	(42)	61,262			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,845	55,845		55,845		55,845			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		55,508	61,641	117,149		117,149	(42)	117,107			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,485,849	330,567	1,253,847	3,070,263		3,070,263	(76,879)	2,993,384			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Nokomis Golden Manor # 0027961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(54)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,190)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,408)	19		17
18	Fines and Penalties				18
19	Entertainment	(84)	17		19
20	Contributions	(75)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,783)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(18,002)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (27,596)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(49,283)	Var	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (49,283)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (76,879)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Nokomis Golden Manor

ID# 0027961

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending machine cost	$ (1,994)	2	1
2	Eliminate 2004 Computer Maintenance	(2,373)	6	2
3	Eliminate Civic Dues	(35)	17	3
4	Record 2003 IHCA Dues	3,848	20	4
5	Offset Ancillary Service Center Refunds	(42)	39	5
6	Staight Line Depr on items required to be capitalized			6
7	For Cost Reporting Pruposes	(17,381)	30	7
8	Offset Maintenance Refunds	(25)	6	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(18,002)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Nokomis Golden Manor # 0027961 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,238)	0	0	0	0	0	0	0	0	0	0	(3,238)	2
3	Housekeeping	0	112	0	0	0	0	0	0	0	0	0	112	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	798	0	0	0	0	0	0	0	0	0	798	5
6	Maintenance	(2,398)	14,789	0	0	0	0	0	0	0	0	0	12,391	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,636)	15,699	0	0	0	0	0	0	0	0	0	10,063	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(119)	(127,736)	0	0	0	0	0	0	0	0	0	(127,855)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,408)	3,027	0	0	0	0	0	0	0	0	0	1,619	19
20	Fees, Subscriptions & Promotions	(3,010)	174	0	0	0	0	0	0	0	0	0	(2,836)	20
21	Clerical & General Office Expenses	0	39,742	0	0	0	0	0	0	0	0	0	39,742	21
22	Employee Benefits & Payroll Taxes	0	11,810	0	0	0	0	0	0	0	0	0	11,810	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	910	0	0	0	0	0	0	0	0	0	910	25
26	Insurance-Prop.Liab.Malpractice	0	2,196	0	0	0	0	0	0	0	0	0	2,196	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(4,537)	(69,877)	0	0	0	0	0	0	0	0	0	(74,414)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(10,173)	(54,178)	0	0	0	0	0	0	0	0	0	(64,351)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Nokomis Golden Manor # 0027961 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(17,381)	4,312	0	0	0	0	0	0	0	0	0	(13,069)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	583	0	0	0	0	0	0	0	0	0	583	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(17,381)	4,895	0	0	0	0	0	0	0	0	0	(12,486)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(42)	0	0	0	0	0	0	0	0	0	0	(42)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(42)	0	0	0	0	0	0	0	0	0	0	(42)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(27,596)	(49,283)	0	0	0	0	0	0	0	0	0	(76,879)	45

Facility Name & ID Number Nokomis Golden Manor # 0027961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jerry & Marilyn King	100.00	Mt. Vernon Countryside Manor	Mt. Vernon	King Management	Nashville	Home Office
Jerry & Marilyn King	100.00	Taylorville Care Center	Taylorville			
Jerry & Marilyn King	100.00	Aviston Countryside Manor	Aviston			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	3	See Schedule VIII	$	King Management Co.	100.00%	$ 112	$ 112	1
2	V	5	See Schedule VIII		King Management Co.	100.00%	798	798	2
3	V	6	See Schedule VIII		King Management Co.	100.00%	14,789	14,789	3
4	V	17	See Schedule VIII	185,000	King Management Co.	100.00%	57,264	(127,736)	4
5	V	19	See Schedule VIII		King Management Co.	100.00%	3,027	3,027	5
6	V	20	See Schedule VIII		King Management Co.	100.00%	174	174	6
7	V	21	See Schedule VIII		King Management Co.	100.00%	39,742	39,742	7
8	V	22	See Schedule VIII		King Management Co.	100.00%	11,810	11,810	8
9	V	25	See Schedule VIII		King Management Co.	100.00%	910	910	9
10	V	26	See Schedule VIII		King Management Co.	100.00%	2,196	2,196	10
11	V	30	See Schedule VIII		King Management Co.	100.00%	4,312	4,312	11
12	V	33	See Schedule VIII		King Management Co.	100.00%	583	583	12
13	V								13
14	Total			$ 185,000			$ 135,717	$ * (49,283)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Nokomis Golden Manor # 0027961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Jerry King	Owner	Mgmt/Consultant	100.00	59,612	13	21.35%	Salary	$ 16,186	17,8	1
2	Denise King	Regional Director	Administrative	0.00	138,992	13	21.35%	Salary	37,740	17,8	2
3	Keith King	Maint. Supervisor	Maintenance	0.00	46,367	11	21.35%	Salary	12,590	6,8	3
4	Leslie Pedtke	Administrator	Administrative	0.00	99,564	0	0.00	Salary	0	17,1	4
5	Elizabeth King	Dietary	Dietary	0.00	2,496	0	0.00	Salary	0	1,1	5
6	Marilyn King	Owner	Mgmt/Consultant	100.00	3,146	1	21.35%	Salary	854	17,8	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 67,370		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Nokomis Golden Manor # 0027961 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: King Management Company, Inc.
Street Address: 935 South Mill Street
City / State / Zip Code: Nashville, IL 62263
Phone Number: (618) 327-3064
Fax Number: (618) 327-3083

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Patient Days	119,399	4	$ 525	$ 525	25,497	$ 112	1
2	5	Utilities	Patient Days	119,399	4	3,738		25,497	798	2
3	6	Maintenance	Patient Days	119,399	4	69,255	58,956	25,497	14,789	3
4	17	Administrative	Patient Days	119,399	4	268,160	256,531	25,497	57,264	4
5	19	Professional Fees	Patient Days	119,399	4	14,175		25,497	3,027	5
6	20	Dues, Fees & Subscriptions	Patient Days	119,399	4	813		25,497	174	6
7	21	Clerical and Office Expense	Patient Days	119,399	4	186,105	131,685	25,497	39,742	7
8	22	Employee Benefits	Patient Days	119,399	4	55,304		25,497	11,810	8
9	25	Other Admin. Staff Transport	Patient Days	119,399	4	4,263		25,497	910	9
10	26	Insurance	Patient Days	119,399	4	10,283		25,497	2,196	10
11	30	Depreciation-Other	Patient Days	119,399	4	11,457		25,497	2,447	11
12	30	Depreciation-Autos	Patient Days	119,399	1	8,733		25,497	1,865	12
13	30	Depreciation-Autos	Direct Costs	N/A	1	0		0		13
14	30	Depreciation-Copiers	Direct Costs	N/A	1	679		0		14
15	33	Real Estate Taxes	Patient Days	119,399	4	2,732		25,497	583	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 636,222	$ 447,697		$ 135,717	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Nokomis Golden Manor # 0027961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Schedule Not Applicable						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Nokomis Golden Manor # 0027961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	34,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	35,399	2
3. Under or (over) accrual (line 2 minus line 1).	$	899	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	37,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	38,099	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	28,577	8
	1999	30,269	9
	2000	31,547	10
	2001	32,871	11
	2002	35,399	12

Line 2: Real Estate Tax Payment was for 2002 tax year

Line 4: Accrual is based on 2002 taxes paid

Line7: $38,099 Real Estate Tax

583 Home Office Allocation

38,682 Total Real Estate Tax

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Nokomis Golden Manor COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0027961

CONTACT PERSON REGARDING THIS REPORT Linda Peppenhorst

TELEPHONE (618) 327-3064 FAX #: (618) 327-3083

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-000-551-51	10-2-188A-1	$ 35,249.72	$ 35,249.72
2.	10-000-188-05	10-2-188A	$ 148.94	$ 148.94
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 35,398.66	$ 35,398.66

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Nokomis Golden Manor # 0027961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,807 B. General Construction Type: Exterior Brick Frame Steel & Brick Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Section Not Applicable

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	217,800	1983	$ 10,000	1
2	Home Office		1989	1,343	2
3	TOTALS	217,800		$ 11,343	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Nokomis Golden Manor # 0027961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	54		1970	1970	$ 466,571	$ 21,958	26	$	$ (21,958)	$ 466,571	4
5	25		1975	1975	205,532		40	5,138	5,138	149,010	5
6	7		1984	1984	45,669		40	1,142	1,142	22,835	6
7	8		1987	1987	104,200	3,872	30	3,473	(399)	59,046	7
8	8		1994	1994	225,527	7,777	40	5,638	(2,139)	55,928	8
	Improvement Type**										
9	Various Improvements			1974	2,187		25	6	6	2,187	9
10	Various Improvements			1980	1,617		25	66	66	1,553	10
11	Morton Building			1982	22,363		20			22,363	11
12	Fire Doors			1986	2,092		10			2,092	12
13	Smoke Detectors			1986	446		10			446	13
14	Floor Coverings			1986	3,700		10			3,700	14
15	Roof			1986	8,940		10			8,940	15
16	Sprinklersystem			1987	11,964		10			11,964	16
17	Boiler Tubes			1987	4,880		10			4,880	17
18	Roof			1988	58,230	1,456	40	1,456		22,929	18
19	Stainless Steel Fire Shutters			1988	4,385	110	40	110		1,691	19
20	15 Ton Carrier Condensing			1989	6,500		10			6,500	20
21	Painting & Wallpapering			1986	1,557		10	157	157	1,417	21
22	Nurse Station Monitors			1992	3,345		10			3,345	22
23	Nurse Station Counters			1992	7,155	477	15	477		5,287	23
24	Grease Trap			1992	2,425		10			2,425	24
25	3 Ton Air Conditioner			1992	2,600		5			2,600	25
26	Nurse Call Station			1993	22,218	1,481	15	1,481		15,305	26
27	Air Cleaner, Heaters			1993	3,838	256	15	256		2,645	27
28	New Road			1994	3,624		5			3,624	28
29	Kick Plates for Doors			1994	2,785	278	10	278		2,508	29
30	Walk in Cooler with Ramp			1996	4,656	310	15	310		2,352	30
31	Three Door Freezer			1996	3,846	256	15	256		1,943	31
32	New Addition - Offices, Activities, Social Services			1996	164,964	6,110	27	6,110		45,315	32
33	Flooring - New Additions			1996	1,368	89	10	89		661	33
34	Lighting - New Additions			1996	1,337	137	15	137		1,015	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Nokomis Golden Manor # 0027961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Phone Wiring - New Addition	1996	$ 1,966	$ 197	10	$ 197	$	$ 1,460	37
38	Plumbing - New Addition	1996	2,045	102	20	102		758	38
39	A/C - New Addition	1996	4,304	430	10	430		3,190	39
40	Blacktop Parking Lot	1997	16,000	1,600	10	1,600		10,400	40
41	Kitchen & Outside Drains	1997	5,476	365	15	365		2,251	41
42	Carpet	1998	3,070	307	10	307		1,740	42
43	80 Gallon Water Heater	1998	2,030	135	15	135		698	43
44	Flooring - Kitchen Tiles	1998	1,877	188	10	188		1,127	44
45	Fire Doors	1998	3,325	332	10	332		1,855	45
46	Sales Tax on New Additions	1998	1,138	114	10	114		617	46
47	Sidewalk	1998	1,965	131	15	131		710	47
48	Air Freshener System	1998	2,927	195	15	195		1,106	48
49	Wallpaper	1999	4,943	494	10	494		2,347	49
50	Tile	1999	22,120	2,212	10	2,212		9,585	50
51	Carpet	1999	3,786	379	10	379		1,546	51
52	Ceramic Tile	1999	3,622	362	10	362		1,479	52
53	Wallpaper	1999	9,913	1,983	5	1,983		8,096	53
54	Carpeting, Painting & Wallpapering	1999	29,338	5,868	5	5,868		23,960	54
55	Vinyl Flooring & Installation	2000	17,547	1,755	10	1,755		7,019	55
56	Wallpapering	2000	7,372	1,474	5	1,474		5,529	56
57	Wall & Door Signs	2000	1,310	262	5	262		939	57
58	New Lighting	2000	968	97	10	97		347	58
59	Window Treatments	2000	2,787	558	5	558		1,998	59
60	Baseboard, Chair Rails, Molding	2000	1,352	90	15	90		315	60
61	Carpeting, Painting & Wallpapering	2000	280	56	5	56		205	61
62	Doors	2000	624	62	10	62		244	62
63	Replace Main Electrical Breaker	2000	6,730	337	20	337		1,318	63
64	Resurface Parking Lot	2000	1,260	126	10	126		441	64
65	Air Conditioners	2000	5,979	598	10	598		2,043	65
66	Concrete & Labor	2000	1,745	116	15	116		358	66
67	Cabinets	2001	28,284	1,414	20	1,414		4,007	67
68	Ceiling Fan	2001	6,720	672	10	672		1,904	68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,603,324	$ 67,578		$ 49,591	$ (17,987)	$ 1,032,669	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Nokomis Golden Manor # 0027961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,603,324	$ 67,578		$ 49,591	$ (17,987)	$ 1,032,669	1
2	Air Conditioner	2001	6,014	601	10	601		1,502	2
3	Fire Doors	2002	13,533	902	15	902		1,654	3
4	Cooling Coil - Kitchen	2002	5,148	515	10	515		558	4
5	Flooring Tile	2002	9,692	969	10	969		1,696	5
6	3 Air Handler Units	2003	12,000	800		800		800	6
7	15 Ton A/C Unit	2003	6,955	464		464		464	7
8	Door Alarm	2003	13,806	460		460		460	8
9	Blinds	2003	2,271	38		38		38	9
10	Water Heater	2003	6,056	168		168		168	10
11	Floor Title & Cove Base	2003	867	14		14		14	11
12	Sidewalk/Patio	2003	4,492						12
13	Hot Water Cooling Coil	2003	1,900	106		106		106	13
14									14
15	Home Office Parking Lot	1989	422					422	15
16	Home Office New Building	1995	20,934		25	837	837	6,838	16
17	Home Office Interior Finishes	1996	1,298		15	86	86	649	17
18	Home Office Carpet	1996	454					454	18
19	Home Office Cabinets	1996	718		20	36	36	269	19
20	Home Office Electrical	1996	249		15	17	17	124	20
21	Home Office Front Door	2002	342		10	34	34	42	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,710,475	$ 72,615		$ 55,638	$ (16,977)	$ 1,048,927	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Nokomis Golden Manor # 0027961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 105,512	$ 9,637	$ 11,266	$ 1,629	5-10	$ 62,499	71
72	Current Year Purchases	50,500	3,597	4,012	415	5-10	4,012	72
73	Fully Depreciated Assets	257,352				5-10	257,352	73
74								74
75	TOTALS	$ 413,364	$ 13,234	$ 15,278	$ 2,044		$ 323,863	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Business	1998 Ford E350 Van	1998	$ 24,406	$	$	$	4	$ 24,406	76
77	Home Office Vehicle	2002 Ford F150 Truck	2002	3,030		757	757	4	1,262	77
78	Home Office Vehicle	2004 Lexus RX 330	2003	8,861		1,107	1,107	4	1,107	78
79										79
80	TOTALS			$ 36,297	$	$ 1,864	$ 1,864		$ 26,775	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,171,479	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 85,849	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 72,780	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (13,069)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,399,565	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? N/A YES N/A NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Section Not Applicable		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Nokomis Golden Manor # 0027961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE 80

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments			1,143		1,143
8	Nurse Aide Competency Tests					
9	TOTALS		$	$ 1,143	$	$ 1,143
10	SUM OF line 9, col. 1 and 2	(e)	$ 1,143			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ None

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,3	hrs	$	7,881	$ 157,168	$	7,881	$ 157,168	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,977	48,290		1,977	48,290	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		7,967	155,688		7,967	155,688	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				55,508		55,508	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab, X-Ray, IV Ther.	39,3				5,796			5,796	13
14	TOTAL			$	17,825	$ 366,942	$ 55,508	17,825	$ 422,450	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Nokomis Golden Manor # 0027961 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2003 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 396,007	$	1
2	Cash-Patient Deposits	1,694		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (11,589))	288,726		3
4	Supply Inventory (priced at)	4,310		4
5	Short-Term Investments	172,188		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 862,925	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,645		13
14	Buildings, at Historical Cost	2,045,818		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	320,007		16
17	Accumulated Depreciation (book methods)	(1,364,968)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,026,502	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,889,427	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 169,195	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,694		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	119,919		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,608		31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,200		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Party	2,145		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 345,761	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 345,761	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,543,666	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,889,427	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Nokomis Golden Manor # 0027961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,795,826	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,795,826	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(20,265)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(225,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **IL Replacement Tax Payable Adj.**	(6,895)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (252,160)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,543,666	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Nokomis Golden Manor # 0027961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,990,801	1
2	Discounts and Allowances for all Levels	(486,657)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,504,144	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	532,854	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 532,854	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	594	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,369	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,963	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,586	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,586	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	5,586	28
28a	Diaper Charges	865	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,451	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,049,998	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	550,579	31
32	Health Care	1,598,083	32
33	General Administration	680,504	33
	B. Capital Expense		
34	Ownership	123,948	34
	C. Ancillary Expense		
35	Special Cost Centers	61,304	35
36	Provider Participation Fee	55,845	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,070,263	40
41	**Income before Income Taxes (line 30 minus line 40)****	(20,265)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (20,265)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Nokomis Golden Manor # 0027961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,849	2,110	$ 46,341	$ 21.96	1
2	Assistant Director of Nursing	318	310	6,079	19.61	2
3	Registered Nurses	5,853	6,363	109,042	17.14	3
4	Licensed Practical Nurses	19,822	21,182	301,841	14.25	4
5	Nurse Aides & Orderlies	62,213	65,933	587,463	8.91	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,875	4,484	38,034	8.48	10
11	Social Service Workers	2,927	3,340	32,024	9.59	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,044	17,215	117,284	6.81	15
16	Dishwashers					16
17	Maintenance Workers	2,211	2,587	30,023	11.61	17
18	Housekeepers	7,724	8,427	57,581	6.83	18
19	Laundry	7,926	8,462	51,559	6.09	19
20	Administrator	1,971	2,152	63,951	29.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,048	2,257	20,756	9.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,084	1,549	23,871	15.41	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	135,865	146,371	$ 1,485,849 *	$ 10.15	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	142	$ 7,124	1,3	35
36	Medical Director	Contract	6,500	9,3	36
37	Medical Records Consultant	8	519	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	1,176	10,3	39
40	Physical Therapy Consultant	187	9,342	10,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	34	2,297	11,3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	371	$ 26,958		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	31	$ 1,183	10,3	50
51	Licensed Practical Nurses	171	5,331	10,3	51
52	Nurse Aides	1,171	22,096	10,3	52
53	TOTAL (lines 50 - 52)	1,373	$ 28,610		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Nokomis Golden Manor # 0027961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan Collman	Administrator	0.00	$ 63,951
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 63,951

B. Administrative - Other

Description	Amount
Management Fees	$ 185,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 185,000

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company	Accounting	$ 10,125
Sandberg, Phoenix & von Gontard	Legal	4,343
Greensfelder, Hemker & Gale	Legal	2,991
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 17,459

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 119,022
Unemployment Compensation Insurance	26,034
FICA Taxes	112,254
Employee Health Insurance	15,628
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	714
Home Office Allocation	11,810
Employee Physicals	
TOTAL (agree to Schedule V, line 22, col.8)	$ 285,462

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section Not Applicable		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,020
Advertising: Employee Recruitment	3,031
Health Care Worker Background Check	720
(Indicate # of checks performed 60)	
Subscriptions	333
IHCA Dues	3,848
Home Office Dues & Subscriptions	174
Other Miscellaneous Dues & Licenses	78
Promotional Advertising	6,783
Less: Public Relations Expense	( )
Non-allowable advertising	(6,783)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,204

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,379
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,379

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Nokomis Golden Manor # 0027961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Schedule Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Nokomis Golden Manor **#** 0027961 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Assoc. - $3,848**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,513** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **55,845**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **None**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **N/A - None** Indicate the amount. $ **None**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **56%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

GOLDEN MANOR NURSING HOME, INC.
IDPH ID #0027961
ATTACHMENT TO SCHEDULE XVII, LINE 28
12/31/03

OTHER REVENUE:

VENDING INCOME	$4,277
REFUNDS & REIMBURSEMENTS	121
INTEREST	20
COST REPORT SETTLEMENT	547
MISCELLANEOUS	621
	5,586